Iowa Department of Human Services
Iowa Medicaid Enterprise (IME)
Claims Editing and Correct Coding Initiative (CCI)
Questions & Answers
August 3, 2009

Question #	Page	Section #	Reference	Question/Request for Clarification/Suggestion
1				What claim system does the Division of Medical Service expect to use for their Medicaid Management Information System? Will the state expect to use the identified claims processing system during the entire term of agreement? **ANSWER:** **Iowa operates a custom MMIS solution. It is a legacy system that has been in place for numerous years. It operates on our IBM Mainframe environment and utilizes VSAM files and the COBOL programming language. It is undetermined if the state will use the current claims processing system during the entire term of agreement. The bidder can assume if the State changes claims processing solutions the change will be coordinated with the vendor. (See narrative in Attachment 1)**

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2				Will there be expectations of a selected code auditing vendor proposing services for integrating their code editing software with designated claims processing system? Will the selected vendor be expected to develop a custom integration for the code editing tool? **ANSWER:** **The Department is anticipating solutions that will accept adjudicated claims, perform the CCI edits looking for overpayment situations, and return the claims to the current claims payment process. However all potential solutions will be considered and evaluated. The Department expects the vendor to come back with recommended denials of procedures, line items or full claims.**

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3				The proposal outlines the Division of Medical Service's parameters around a CCI editing requirement. Does the state wish to expand the scope of the editing to address any other categories of editing capabilities beyond CCI? If so, please describe. **ANSWER:** **The department will consider editing capabilities beyond those that are defined as part of the Correct Coding Initiative. We encourage bidders to document the types of editing available in the proposed solution.**
4				In Attachment K, the Claims Summary table has six different categories of information provided; Nursing, Medical, Waiver, Inpatient, Outpatient and Dental. Can you provide more clarification around these categories with a detailed description of each? Specifically, please address whether Medical, refers to professional claims only? **ANSWER:** **RFP Attachment "K" lists the provider type in the left column. Attachment 2 below provides definitions for those type numbers.**

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5				Please clarify the annual claim volume outlined in the categories referenced in question No. 4. **ANSWER:** **See answer above for question #4.**
6				Under Attachment L, can you define what is meant by Contingency Fee? **ANSWER:** **A fee payable in the event of a successful or satisfactory outcome. A fixed percentage.**
7				Would it be possible to obtain a copy of the Request for Proposal in Microsoft Word? **ANSWER:** **No, the RFP is not available in Word.**

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8				Can you provide your outbound file format and any supporting documentation for both CMS 1500 and UB04 claims? Can you make a sample file available? **ANSWER:** **The outbound claim format will be developed to the vendors specifications according to the solution selected. The vendor may assume that claim data items relevant to HIPAA defined transactions will be available in the specifications.**
9				Do you have an expected inbound file format for both CMS 1500 and UB04 claims? If so, can you provide the file format and any support documentation? **ANSWER:** **The inbound claim format will be developed with the selected vendor. At a minimum the inbound transaction will include all data items in the outbound transaction, the adjusted net payment amount, and the appropriate code or description documenting the adjustment reason.**

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10				Our interpretation of the RFP's Scope of Work is that the Department is requesting a vendor to provide a "scrubber" solution where all Medicaid claims will be submitted and edited for accuracy, and those which are inaccurate we would then be responsible for providing information on why they were rejected and submitting them back to the IME Claims Processing System where it will then be recoded into compliance. Our responsibilities will include providing the scrubber system and the coding staff to review the uncorrected claims and providing information when sending those claims back to the IME. If our interpretation is inaccurate, please provide an additional explanation as to what you are expecting of vendors. **ANSWER:** **The MMIS currently processes and adjudicates each claim making a determination of payment or denial. The Department is seeking a solution that will reviewed the claims set for payment and apply business rules to ensure claims have been priced accurately. It is anticipated that solution will include medical coding expertise and data mining techniques to ensure that services are appropriately bundled, do not include duplication, do not have mutually exclusive codes, etc. For more information please refer to section 1.1 of the RFP.** **Claims will not be recoded or corrected on behalf of the providers. The final result will either be payment, reduced payment, or denial of a claim.**

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11				Please verify that the Department is not requesting that vendor's personnel be onsite at the IME's location. **ANSWER:** **The Department does not expect the vendor's personnel be onsite at the IME.**
12				Please provide more information on the system which the IME is currently using which vendors would be required to interface with? The more information which the Department can provide—such as name of your system, how long you have used it, its configuration, any system requirements that our system would need in order to successfully interface with yours, etc.—the more helpful it will be in preparing a proposal response. **ANSWER:** **Please see the response to question #1. The department anticipates interfaces will occur through the secure exchange of data files or data messages. The department will partner with the selected vendor to create the interfaces.**

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13				Please clarify if vendors' Coders will simply be verifying that charts have been incorrectly coded and then send them back to the IME or that vendors' Coders will have to correct all charts that have inaccurate information and then send them back to the IME. **ANSWER:** **Claims are to be evaluated by the vendor and returned with no change to pricing. Any adjustments in pricing are to be accompanied with the appropriate reason for the adjustment. Vendors are reviewing claims information only (no medical records or charts). The Department does not expect the vendor to recode claims.**
14				The Department states that it currently has contracts in place with several vendors for various services, as listed on pages 3 and 4, under 1.2.1. The Department writes in the RFP that no current vendors will be allowed to bid on this RFP. Has the Department experienced any challenges, problems, or incidents with the current contractors providing these services, which should be addressed in our proposal? **ANSWER:** **No**

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15				Is it the Department's expectation that a single vendor will be required to provide all of these services or will multiple awards be made? **ANSWER:** **A single vendor.**
16				The 2008 Claims Summary Report listed on pages 74 and 75 in the RFP details the types of claims coded. Please confirm that the total—5,832,855—is the total number of claims that were scrubbed for being inaccurate? **ANSWER:** **In FY08 our claim volume was 5.8 Million. This claim volume may fluctuate up or down depending upon the volume of Medicaid members and their medical needs. Going forward we anticipate a similar claim volume.**

Question #	Page	Section #	Reference	Question/Request for Clarification/Suggestion
17	**11**	**3.1**	The Department prefers that this be a contingency based fee schedule. The contingency fee will be based on actual savings by the Department per month.	▪ How will the contingency fee be defined by the vendor? **ANSWER:** **The department expects the vendor to describe the suggested fee schedule in the proposal. Department savings will be determined by comparing the pricing of the adjudicated claims sent from the Department to the vendor, against the accepted pricing from the vendor after the edits have been applied.** **See answer to #6.** ▪ How will the Department pay fees Monthly? Would the Department consider allowing the proposers to bid a "Shared Savings Percentage" to be multiplied by the monthly claims savings? **ANSWER:** **See Section 2.1(6) of the Contract Special and General Contract Terms. Based on the contingency fee (set percentage) monthly payment will be made according to this section.** **The department will consider all vendor payment proposals.** ▪ Would the Department consider defining a "Shared Savings Percentage" to be implied based on a ratio of bidder's "Aggregate Fee" divided by the bidder's "Aggregate Proposed Savings?" **ANSWER:** **The department will consider all vendor payment proposals.**

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18	**15**	**3.2.3.2**	**Configure Claim Editing Process Section** "Contract will develop the programs designed to interface the Claim Editor with the MMIS claims processing."	▪ Can the Department provide more detail on how the CCI vendor will be expected to collaborate with the MIS vendor and state staff on any required reprogramming to the MMIS system? **ANSWER:** **The vendor will be expected to work with the MMIS contractor regarding communication and coordination of data file transfers and the interpretation of returned data. It is anticipated that the current MMIS contractor will be responsible for any programming modifications to the MMIS system to support the CCI process. The vendor proposal should document deliverables expected from the MMIS contractor and deliverables provided back to the MMIS system.**
19	**19**	**3.2.6.2**	**Training Section** Key Activity: On-going service level agreement. "Provide copies of all system documentation, including user manuals and code summaries.	▪ Can the Department provide a description of the documentation expected for code summaries? **ANSWER:** **Code summaries would be table descriptions that match coded data values to a meaningful description. Of particular interest will be coding describing pricing adjustments as a result of claim editing.**

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20	**22/61**	**4.2.3/ Attachment A, #2**	**Mandatory Requirements Checklist** Bidders must "…write the response immediately after the restated requirements?	▪ Does "restated requirement" mean restating only the Key Activity, or must all components (key activity, contractor responsibilities, deliverables, and performance measures) be restated, with a response under each major heading and subheading? **ANSWER:** **Restate Section # and Key Activity only.**
21	**26**	**4.2.7**	**Certification and Guarantees by the Bidder**	▪ There appears to be a typographical error such that numbers "skip" or are non-sequential (from 4.2.7.3 to 4.2.8.4). The Department may wish to correct this error. **ANSWER:** **Thank you for bringing this to our attention. Should an amendment to the RFP be necessary this will be corrected.**

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22	**30**	**5.4.3**	**Scoring of Bidder Cost** Bidders should submit a contingency fee cost proposal. The cost proposal providing the greatest benefit to the Department will receive the maximum points. This based on Section 3-Service Requirements cost only.	▪ The current formula to determine points in the cost section may not be consistent with the Department's intent. 5.4.3 states, "The cost proposal providing the greatest benefit to the Department will receive maximum points." However, the cost section asks only for fees. The "benefit" to the Department could be defined as "Net Savings" which is the total claim savings to the Department less any fees paid by the Department for these services. Will the Department consider an alternative scoring formula to take into account the Department's "Net Savings" defined as "gross claim savings" less vendor fees? **ANSWER:** **The Department is contemplating an amendment to the RFP to clarify the calculation of contingent fees and savings. An amendment to the RFP will be issued shortly.**

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23	**52**	**2.2(11)**	**Intellectual Property** (a) ownership and Assignment of Other Deliverables – Contractor agrees that the State and Department shall become the sole and exclusive owners of all Deliverables.	▪ The CCI Contractor will be delivering a service and the expertise associated with that service. What intellectual property does the Department foresee that could be subject to this provision? **ANSWER:** **Any software or coding directly associated with the Iowa Medicaid MIS must be owned by the State of Iowa. Therefore, any software or coding needed to extract and send claims to the CCI vendor, and any software or coding needed to receive output from the CCI vendor must be owned by the State. Beyond this, the questioner is correct in stating that this is a service contract, and the state will have no claim to the vendor's other proprietary software.**

Suggestion #	Page	Section #	Reference	Suggestion
1	**11**	**3.1**	**Introduction**	The Department states in 3.1, "The Department prefers this (RFP) be a contingency based fee schedule. The contingency fee will be based on actual savings by the Department per month." This is an appropriate goal to ensure that this RFP does not cost the Department any new monies. Fees paid to any vendor should come solely out of "Gross Claim Savings" to ensure the Department has a "Net Savings" after fees are paid. **ANSWER:** **The Department is taking the suggestion under consideration.**

Suggestion #	Page	Section #	Reference	Suggestion
2	**30**	**5.4.3**	**Scoring of Bidder Cost Proposals**	5.4.3 states, "The cost proposal providing the greatest benefit to the State will receive the maximum points." However, the current structure of the RFP may not accomplish this goal. If, under the current cost scoring section, costs are interpreted to be defined as fees, the lowest cost bidder could receive the highest score, even if they achieve the lowest savings – which would not be the "greatest benefit to the State." For example, assume Vendor A bids a fee of $1 but saves only $3; while Vendor B bids a fee of $ and saves $12. The "Net Savings" to the Department for Vendor A is $2 ($3 savings less $1fee), and $8 ($12 savings less $4 fee) for Vendor B; however, Vendor A cold receive 600 Cost Section points while Vendor B would only receive 150 points (2%% of 600). The Department may want to consider a scoring proposal to recognize the "Net Savings" which is the "greatest benefit to the Department." If a "Net Savings" approach is used, then Vendor B would appropriate get the maximum points since they save the Department $8. The formula to assign other vendors would be based on the formula "Bidder's Cost Score = (Bidder's "Net Savings"/Highest Bidder's "Net Savings") x Maximum Points. In this case Vendor A would get 150 points (Vendor A "Net Savings"/Vendor B "Net Savings" = 2/8 = 25%) of 600.

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				<u>Scoring Proposal</u> Listed below are the proposal terms of a common "Net Savings" model that address how to best achieve the Department's goal of providing maximum points to cost proposals that provide the "greatest benefit to the State." This proposal addresses the following terms: Proposed Savings Timeframes (for scoring and contract guarantees) Scoring Formula Monthly Fees (timing and amount) Protections to the Department <u>Proposed Savings</u> Bidders should be expected to achieve their proposed amount of claim savings. The Department should consider some scoring protections from Vendors bidding a very low fee but not achieving significant savings. This model protects the Department from vendors who will under-deliver on over-promised savings in order to "win the bid."

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				<u>Timeframes</u> The Department may want to consider a period of three years for purposes of cost proposal scoring and contract terms. Even though a vendor's solution will not be implemented for the full 3 years, the bidder's proposal savings should take this into account. Thjs will incentivize a bidder to implement their solution on schedule. This will also allow the Department to better compare each vendor's bids because their proposed savings amounts will be a function of both their saving potential but also how fast they can implement their solution. For example, if two vendors are equal in terms of proposed savings and fees, but one vendor can implement 3 months sooner, then that vendor can build in 3 more months of aggregate savings over the 3 year period. <u>Scoring Formula</u> Scoring each vendor's "Net Savings" is the only for the Department to truly compare bidders on an apples-to-apples basis. Therefore the Department may want tot consider a scoring formula that takes into account the net difference between each bidder's proposed three year savings and each bidder's three year cumulative fee. (note that a three year cumulative fee also allows the Department to appropriately compare vendor's fees that may be structured differently.)

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				Listed below are the terms of the proposed scoring formula: The bidders shall bid a three year "Aggregate Fee" dollar amount in conjunction with a three year "Aggregate Proposed Savings" dollar amount. The difference between the "Aggregate Proposed Savings" and the "Aggregate Fee" will be defined as the "Aggregate Net Savings." The Cost Section will award the maximum points to the vendor with the highest "Aggregate Net Savings." Other vendors will receive points based on the formula: Bidder's Cost Score = (Bidder's "Aggregate Net Savings"/Highest Bidder's "Aggregate Net Savings") x Maximum Points. <u>Monthly Fees</u> The ration of "Aggregate Fee" to "Aggregate Proposed Savings" could be imputed to equal the "Share Savings Percentage." On a monthly basis, the Department can pay a fee equal to the "Shared Savings Percentage" multiplied by the claim savings. Since the savings do not start to accrue immediately upon the contract start date, monthly fees do not have to begin until savings begin to accrue. Fees could be paid to the vendor 15 or 30 days following the month that the savings were achieved.

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				Alternatively, the Department may want to pay the vendor a monthly fee in advance of implementation to better itemize implementation costs for enhanced federal matching purposes. If this is done, the state could recoup these costs from the vendor's monthly fees once implementation and savings start to accrue. After the first three contract years, if the Department is satisfied with the vendor's "Shared Savings Percentage", the Department can continue paying the vendor based on this methodology with or without a new "Aggregated Proposed Savings." <u>Protections to the Department</u> It is supremely important for the Department to protect against vendor's overinflating their savings assumptions just to win the bid. To protect the Department, listed below are two suggestions that are not onerous or unreasonable. The Department may want to consider requesting that bidders provide at least three client references to validate the savings assumptions included in their bid. The references should make certain that the level of savings are consistent with the solution included in the bidder's RFP response. **ANSWER:** **The Department is taking the suggestion under consideration.**

ATTACHMENT 1

The MMIS processes all Iowa claim forms and a variety of electronic media claims (EMC) including transfers from claims clearing houses, and direct computer data transfer. All claims entered into the subsystem are processed similarly according to claim type, regardless of the initial format of the claim document.

Because of the number of various EMC formats required to support Iowa Medicaid billing, preprocessing is performed to reformat the various inputs into the MMIS claim layout.

The system determines to either pay or deny a service according to criteria on the Exception Control File. This parameter table, which is maintained online, enables the State to control the disposition of edits and audits without any programming effort involved. Separate exception codes are posted for each edit/audit exception for each line item. Each exception code can be set to several dispositions depending on such factors as input media (paper or magnetic tape), as well as claim type. Claim type is assigned to a claim by a combination of claim invoice and other indicators within the claim. A table explaining the determination of claim type may be found in the Exhibit chapter, titled "Claim Type Assignment Table."

If all exceptions on a claim have a disposition of pay, deny, or pay and report, the claim is adjudicated and the payment amount is computed according to the rules and regulations of the State of Iowa. If any exception for the claim is set to suspend, then the claim is either printed on a detail suspense correction report or listed for an online suspense correction, as dictated by parameters on the Exception Control File. A "super suspend" disposition is used for edits so severe that no resolution short of correcting the error is possible (invalid provider data, for instance). The "pay and report" disposition allows the Department to test the impact of a new exception and decide how to treat the condition in the future (pay, deny, educate providers...). Claims with special exception codes are routed according to Department instructions. The specific unit (including Department) responsible for correction of an exception is designated by the location code on the exception control file. Again, this can be readily changed online.

The Advanced MMIS also allows the detail and summary resolution text to be entered on the Text File of the Reference Subsystem. This information is then available to the resolution staff during exam entry, suspense correction, and inquiry processes, thus providing an online resolution manual.

A remittance advice is produced for every claim in the system and shows the amount paid and the reasons for claim denial or suspense. The message related to each exception code is controlled by parameters on the Exception Control File. A different

message can be printed according to claim submission media, claim type, and whether the claim is denied or suspended. The actual text of the message is maintained online on the Text File.

The MMIS maintains 36 months of adjudicated claims history online. These claims, as well as all claims in process, are available for online inquiry in a variety of ways. Claims can be viewed by recipient ID, provider number, NPI, claim Transaction Control Number (TCN), or a combination of the above. These search criteria can be further limited by a range of service dates, payment dates, payment amounts, billed amounts, claim status, category of service, procedure codes, or diagnosis codes within a claim type. Claims can be displayed either in detail, one claim per screen, or in summary format, and several claims per screen. Additional inquiry capability allows the operator to browse the Recipient, Provider, or Reference files from the claim screen to obtain additional information related to the claim. A summary screen is also available for each provider containing month-to-date, year-to-date, and most recent payment information.

The Claims Processing Subsystem has the capability to suspend or deny claims based on TPL information carried in the MMIS files. Additional details on these edits are provided in "Claim Edits and Audits," as well as in the TPL Subsystem description.

The Advanced MMIS supports cost containment and utilization review by editing claims against the prior authorization record to ensure that payment is made only for treatments or services which are medically necessary, appropriate, and cost-effective. The UR Criteria File provides a means of placing program limitations on service frequency and quantity, as well as medical and contraindicated service limits. It provides a means for establishing prepayment criteria, including cross-referencing of procedure and diagnosis combinations.

The Claims Processing Subsystem contains a Claims Processing Assessment System (CPAS) module designed to provide claim sampling and reporting capability required to support the Department in conducting CPAS reviews.

Each step in document receipt processing and disposition includes status reporting and quality control. The Iowa MMIS generates several reports useful in managing claim flow and resolution. Reports are used to track the progress of claims at each resolution location, identify potential backlogs, pinpoint specific claims that have suspended, monitor workload inventories, and ensure timely processing of all pended claims. Meanwhile, Quality Control monitors all operations for adherence to standards and processing accuracy in accordance with contractual time commitments and error rates.

ATTACHMENT 2

Type Code	Type Description
01	GENERAL HOSPITAL
02	PHYSICIAN MD
03	PHYSICIAN DO
04	DENTIST
05	PODIATRIST
06	OPTOMETRIST
07	OPTICIAN
08	PHARMACY
09	HOME HEALTH AGENCY
10	INDEPENDENT LAB
11	AMBULANCE
12	MEDICAL SUPPLIES
13	RURAL HEALTH CLINIC
14	CLINIC
15	PHYSICAL THERAPIST
16	CHIROPRACTOR
17	AUDIOLOGIST
18	SKILLED NURSING FACILITY
19	REHAB AGENCY
20	INTERMEDIATE CARE FACILITY
21	COMMUNITY MH
22	FAMILY PLANNING
23	RESIDENTIAL CARE FACILITY
24	HEALTH MAINTENANCE ORGAN
25	ICF MR STATE
26	MENTAL HOSPITAL
27	COMMUNITY BASED ICF/MR
28	PARA PROFESSIONAL

29	PSYCHOLOGIST
30	SCREENING CENTER
31	HEARING AID DEALER
32	OCCUPATIONAL THERAPIST
33	TAPE INTERMEDIARY
34	ORTHOPEDIC SHOE DEALER
35	MATERNAL HEALTH CENTER
36	AMBULATORY SURGICAL CENTER
37	IME DEFAULT PROVIDER
38	CERTIFIED NURSE MIDWIFE
39	BIRTHING CENTER
40	AREA EDUCATION AGENCY
41	PSYCH MEDICAL INST CHILDREN
42	MEP CASE MANAGER
43	ADULT REHAB
44	CRNA
45	HOSPICE
46	PREPAID HEALTH PLAN
47	HIPP
48	CLINICAL SOCIAL WORKER
49	FEDERAL QUAL HEALTH CENTER
50	NURSE PRACTITIONER
51	THERAPEUTIC TREATMENT SERVICE
52	NURSING FACILITY - MENTAL ILL
53	MENT HLTH SUBSTANCE ABUSE PLN
54	COUNTY RELIEF
55	LEAD INSPECTION AGENCIES
56	LOCAL EDUCATION AGENCY
57	EARLY ACCESS SVC COORDINATOR
58	PACE
59	INDIAN HEALTH SERVICE
60	INSTITUTIONAL - GENERAL
61	OTHER PRACTITIONER - GENERAL
62	BEHAVIORAL HEALTH

63	REMEDIAL SERVICES
64	HABILITATION SERVICES
83	MEDICALLY NEEDY ONLY
86	NON PROVIDER MAIL ONLY
97	RCF GUARDIAN
98	LIENHOLDER
99	WAIVER